No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, ET AL.,
Petitioners,

v.

KIRK COLE, COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR SOCIAL SCIENCE RESEARCHERS AS AMICI CURIAE IN SUPPORT OF PETITIONERS

ANTON METLITSKY
O'MELVENY & MYERS LLP
Times Square Tower
7 Times Square
New York, NY 10036
(212) 326-2000

WALTER DELLINGER
(*Counsel of Record*)
wdellinger@omm.com
DARCY M. MEALS
JEREMY R. GIRTON*
O'MELVENY & MYERS LLP
1625 Eye Street, N.W
Washington, D.C. 20006
(202) 383-5300

*Not yet admitted; supervised by principals of the firm.

Attorneys for Amici Curiae

TABLE OF CONTENTS

Page

INTEREST OF AMICI CURIAE 1

INTRODUCTION AND SUMMARY OF ARGUMENT 2

ARGUMENT 5

I. TEXAS CLAIMS THAT HB2 PROTECTS WOMEN'S HEALTH, BUT ABORTION IS ALREADY VERY SAFE, AND HB2 DOES NOT MAKE IT SAFER. 5

A. Abortion Is a Safe, Common Medical Procedure. 5

B. Strict Regulations Like HB2 Do Not Apply to Many Outpatient Procedures that Are Riskier than Abortion 9

C. Research Demonstrates that These Two Provisions of HB2 Will Not Raise the Quality of Care or Promote Women's Health 11

II. HB2 AND OTHER TRAP LAWS RESTRICT ACCESS TO ABORTION BY REDUCING THE NUMBER OF AVAILABLE PROVIDERS. 15

A. HB2's Primary Effect Will Be to Reduce the Number of Abortion Providers. 15

TABLE OF CONTENTS
(continued)

Page

B. Research Shows that TRAP Laws Close Abortion Facilities and Do Not Protect Women's Health..... 18

III. RESTRICTING ACCESS TO ABORTION ACTIVELY HARMS WOMEN'S HEALTH AND WELLBEING..... 25

A. Delaying or Effectively Denying Access to Abortion Negatively Affects Women's Physical Health. 25

B. Restricting Access to Abortion Does Not Improve Women's Mental and Emotional Health. 30

C. Barriers to Abortion May Have Negative Socioeconomic Effects on Women and Children..... 32

CONCLUSION..... 35

TABLE OF AUTHORITIES

Page(s)

CASES

Fargo Women's Health Org. v. Schafer,
507 U.S. 1013 (1993)..... 18

Gonzales v. Carhart,
550 U.S. 124 (2007)..... 1, 30

Jackson Women's Health Org. v. Currier,
760 F.3d 448 (5th Cir. 2014)..... 22

Planned Parenthood of Se. Pa. v. Casey,
505 U.S. 833 (1992).....30, 35

Planned Parenthood of Se. Pa. v. Casey,
947 F.2d 682 (3d Cir. 1991), *aff'd in part, rev'd in part*, 505 U.S. 833 (1992)..... 18

Planned Parenthood of Wis., Inc. v. Schimel,
806 F.3d 908 (7th Cir. 2015)..... 21

Planned Parenthood of Wis., Inc. v. Van Hollen,
738 F.3d 786 (7th Cir. 2013)..... 12

Whole Woman's Health v. Cole,
790 F.3d 563 (5th Cir.), *modified*, 790 F. 3d 598 (5th Cir.), *and cert granted*, 136 S. Ct. 499 (2015).....2, 5, 12, 19

Whole Woman's Health v. Lakey,
46 F. Supp. 3d 673 (W.D. Tex. 2014), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir.), *modified*, 790 F.3d 598 (5th Cir.), *and cert. granted*, 136 S. Ct. 499 (2015)..... 19

TABLE OF AUTHORITIES
(continued)

Page(s)

Whole Woman's Health v. Lakey,
769 F.3d 285 (5th Cir.), *vacated in part*, 135 S. Ct. 399 (2014) 18

STATUTES

25 Tex. Admin. Code § 139.56(a) 13

La. Stat. Ann. § 40:1061.10(A)(2)(a) 21

Mich. Comp. Laws § 333.20115(2) 22

Mo. Rev. Stat. § 197.200(1) 22

Tex. Health & Safety Code Ann.
§ 171.0031(a)(1)(A) 2

Tex. Health & Safety Code Ann.
§ 171.004 20

Tex. Health & Safety Code Ann.
§ 171.044 26

Tex. Health & Safety Code Ann.
§ 243.002(1) 14

Tex. Health & Safety Code Ann.
§ 243.004(1) 11

Tex. Health & Safety Code Ann.
§ 245.010(a) 2

Tex. Health & Safety Code Ann.
§§ 171.011 to 171.018 ..... 19, 23

Tex. Health & Safety Code Ann.
§§ 171.041 to 171.048 20

Tex. Health & Safety Code Ann.
§§ 171.061 to 171.064 19

TABLE OF AUTHORITIES
(continued)

Page(s)

Texas House Bill 2
83rd Leg., 2nd Spec. Sess. (Tex. 2013) (codified at Tex. Health & Safety Code Ann. §§ 171.0031, 171.041 to .048, 171.061 to .064, 245.010 to .011) 2

Va. Code Ann. § 32.1-127(B)(1) 22

OTHER AUTHORITIES

Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics,
Tex. Pol'y Evaluation Project Res. Brief (Oct. 5, 2015), https://utexas.app.box.com/AbortionWaitTimeBrief 17

Linda A. Bartlett, et al., *Risk Factors for Legal Induced Abortion—Related Mortality in the United States*,
103 Obstetrics & Gynecology 729 (2004) 9

Ian M. Bennett, *Early Abortion in Family Medicine: Clinical Outcomes*,
7 Annals Family Med. 527 (2009) 8

Cynthia J. Berg et al., *Overview of Maternal Morbidity During Hospitalization for Labor and Delivery in the United States*,
113 Obstetrics & Gynecology 1075 (2009) 26

TABLE OF AUTHORITIES
(continued)

Page(s)

M. Antonia Biggs et al., *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*, 105 Am. J. Pub. Health 2557 (2015) 31, 32

M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, BMC Women's Health, July 2013, at 1 .....32, 34

Marianne Bitler & Madeline Zavodny, *The Effect of Abortion Restrictions on the Timing of Abortions*, 20 J. Health Econ. 1011 (2001) 25

Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion*, 16 Guttmacher Pol'y Rev. 18 (2013)..... 20

James W. Buehler et al., *The Risk of Serious Complications from Induced Abortions: Do Personal Characteristics Make a Difference?*, 153 Am. J. Obstetrics & Gynecology 14 (1985)..... 8

William M. Callaghan et al., *Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States*, 120 Obstetrics & Gynecology 1029 (2012)..... 27

TABLE OF AUTHORITIES
(continued)

Page(s)

Georgina Castro et al., *Outpatient Colonoscopy Complications in the CDC's Colorectal Cancer Screening Demonstration Program*, 119 Cancer (Supp. S15) 2849 (2013) 10

Willard, Jr. Cates et al., *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Planning Persp. 260 (1977) 26

Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436 (2008) 30

Susan A. Cohen, *Still True: Abortion Does Not Increase Women's Risk of Mental Health Problems*, 16 Guttmacher Pol'y Rev. 13 (2013) 30

Complications of Colonoscopy, 74 Am. Soc'y of Gastrointestinal Endoscopy 745 (2011) 10

Edward M. D'Eramo et al., *Anesthesia Morbidity and Mortality Experience Among Massachusetts Oral and Maxillofacial Surgeons*, 66 J. Oral & Maxillofacial Surgery 2421 (2008) 10

Fact Sheet: Induced Abortion in the United States, Guttmacher Inst. (July 2014), http://www.guttmacher.org/pubs/fb_induced_abortion.html 7

TABLE OF AUTHORITIES
(continued)

Page(s)

Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008*, 104 Am. J. Pub. Health S43 (Supp. 1, 2014) 6

Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Persp. on Sexual & Reprod. Health 110 (2005) 33, 34

D.G. Foster et al., *A Comparison of Depression and Anxiety Symptom Trajectories Between Women Who Had an Abortion and Women Denied One*, 45 Psychol. Med. 2073 (2015) 31

Diana Greene Foster & Katrina Kimport, *Who Seeks Abortions at or After 20 Weeks?*, 45 Persp. on Sexual & Reprod. Health 210 (2013) 24, 25

Diana Greene Foster et al., Oral Presentation at the American Public Health Association 140th Annual Meeting: Socioeconomic Consequences of Abortion Compared to Unwanted Birth (Oct. 30, 2012), https://apha.confex.com/apha/140am/webprogram/Paper263858.html 33

TABLE OF AUTHORITIES
(continued)

Page(s)

Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, 16 Guttmacher Pol'y Rev. 7 (2013)..... 22

Alisa B. Goldberg et al., *Manual Versus Electric Vacuum Aspiration for Early First-Trimester Abortion: A Controlled Study of Complication Rates*, 103 Obstetrics & Gynecology 101 (2004)..... 8

Jose Granell et al., *Safety of Outpatient Tonsillectomy in Children: A Review of 6 Years in a Tertiary Hospital Experience*, 131 Otolaryngology—Head & Neck Surgery 383 (2004)..... 10

D. Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Tex. Pol'y Evaluation Project Res. Brief (Nov. 17, 2015), https://utexas.app.box.com/KOESelfInductionResearchBrief 27, 28, 29

Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496 (2014) .....passim

Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reprod. Health Matters 136 (2010)..... 28

TABLE OF AUTHORITIES
(continued)

Page(s)

Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73 (2014) 27, 28

Stanley K. Henshaw et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, Guttmacher Inst. 27 (June 2009), https://www.guttmacher.org/pubs/MedicaidLitReview.pdf.....23, 24, 25

How Dangerous is Lightning?, Nat'l Weather Service, http://www.lightningsafety.noaa.gov/odds.shtml (last visited Dec. 30, 2015)..... 9

Jennifer A. Hutcheon et al., *Medicaid Pregnancy Termination Funding and Racial Disparities in Congenital Anomaly-Related Infant Deaths*, 125 Obstetrics & Gynecology 163 (2015)..... 29

Jenna Jerman & Rachel K. Jones, *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, 24 Women's Health Issues e419 (2014)..... 23

Rachel K. Jones & Lawrence B. Finer, *Who Has Second-Trimester Abortions in the United States?*, 85 Contraception 544 (2012) 17

TABLE OF AUTHORITIES
(continued)

Page(s)

Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 Persp. on Sexual & Reprod. Health 3 (2014) 6, 7, 9, 14

Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology 1358 (2011)..... 5

Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173 (2013).....24, 25

Rachel K. Jones et al., *Characteristics of U.S. Abortion Patients, 2008*, Guttmacher Inst. (May 2010), https://www.guttmacher.org/pubs/US-Abortion-Patients.pdf..... 6, 32

Rachel K. Jones et al., *"I Would Want to Give My Child, Like, Everything in the World": How Issues of Motherhood Influence Women Who Have Abortions*, 29 J. Fam. Issues 79 (2008)..... 34

Theodore J. Joyce et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review*, Guttmacher Inst. (Apr. 2009), https://www.guttmacher.org/pubs/MandatoryCounseling.pdf. 19, 23

TABLE OF AUTHORITIES
(continued)

Page(s)

Theodore Joyce, *The Supply-Side Economics of Abortion*, 365 N. Eng. J. Med. 1466 (2011) 20, 25

Lisa M. Keder, *Best Practices in Surgical Abortion*, 189 Am. J. Obstetrics & Gynecology 418 (2003)..... 7

Jennifer Ludden, *Court Decision On Texas Abortion Law Could Hasten Clinic Closures*, Nat'l Public Radio (June 10, 2015), http://www.npr.org/sections/health-shots/2015/06/10/413318079/in-texas-federal-court-backs-abortion-restriction-law..... 14

Brenda Major et al., *Abortion and Mental Health: Evaluating the Evidence*, Am. Psychologist, Dec. 2009, at 863 31

Brenda Major et al., Report of the APA Task Force on Mental Health and Abortion, 2008, http://www.apa.org/pi/women/programs/abortion/mental-health.pdf.....30, 31

Marshall H. Medoff, *The Relationship Between Restrictive State Abortion Laws and Postpartum Depression*, 29 Soc. Work Pub. Health 481 (2014) 29

Nat'l Abortion Fed'n, 2015 Clinical Policy Guidelines (2015)..... 13

TABLE OF AUTHORITIES
(continued)

Page(s)

Katharine O'Connell et al., *First-Trimester Surgical Abortion Practices: A Survey of National Abortion Federation Members*, 79 Contraception 385 (2009) 7

Karen Pazol et al., *Morbidity & Mortality Weekly Report: Abortion Surveillance — United States, 2012*, Ctrs. for Disease Control & Prevention (Nov. 27, 2015), http://www.cdc.gov/mmwr/pdf/ss/ss6410.pdf..... 6, 9

Lisa M. Peacock et al., *Transition to Office-based Obstetric and Gynecologic Procedures: Safety, Technical, and Financial Considerations*, 58 Clinical Obstetrics & Gynecology 418 (2015)..... 11

Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012)..... 9, 27

S.C.M. Roberts et al., *Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges*, 91 Contraception 368 (2015) 21

Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues e211 (2014).....22, 23, 24, 25

TABLE OF AUTHORITIES
(continued)

Page(s)

Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC Med., Sept. 2014, at 1 29

Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, PLOS ONE (July 8, 2015), http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0128832&representation=PDF 31, 32

Corinne H. Rocca et al., *Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States*, 45 Persp. on Sexual & Reprod. Health 122 (2013) 30, 31

Sandhya Somashekhar, *Admitting-Privileges Laws Have Created High Hurdle for Abortion Providers to Clear*, Wash. Post (Aug. 10, 2014), https://www.washingtonpost.com/national/2014/08/10/62554324-1d88-11e4-82f9-2cd6fa8da5c4_story.html 12

State Policies in Brief: Medication Abortion, Guttmacher Inst. (Jan. 1, 2016), http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf. 19

TABLE OF AUTHORITIES
(continued)

Page(s)

State Policies in Brief: State Policies on Later Abortions, Guttmacher Inst. (Dec. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_PLTA.pdf 20

State Policies in Brief: Targeted Regulation of Abortion Providers, Guttmacher Inst. (Dec. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf 19, 21

Julia R. Steinberg et al., *Abortion and Mental Health: Findings from the National Comorbidity Survey-Replication*, 123 Obstetrics & Gynecology 263 (2014) 31

Tex. Dep't of State Health Servs., *Vital Statistics Annual Reports*, http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm (last updated Oct. 15, 2015) 9

Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options, Tex. Pol'y Evaluation Project Res. Brief (Nov. 17, 2015), https://utexas.app.box.com/WExSelfInductionResearchBrief 27

Trends in the States, 2015, Guttmacher Inst., http://www.guttmacher.org/statecenter/updates/2015/statetrends42015.html (last visited Jan. 2, 2016) 3

TABLE OF AUTHORITIES
(continued)

Page(s)

Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. of Pub. Health 1687 (2014) 24, 25, 26

Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015) 8, 12, 13, 26

Ushma Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, BMC Women's Health, Nov. 2015, at 1 34

Richard D. Urman et al., *Safety Considerations for Office-Based Obstetric and Gynecologic Procedures*, 6 Revs. Obstetrics & Gynecology e8 (2013) 11

Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454 (2013) 8

What is Medical Abortion?, Nat'l Abortion Fed'n (Sept. 2008), http://5aa1b2xfmfh2e2mk03kk8rsx.wpengine.netdna-cdn.com/wp-content/uploads/medical_abortion.pdf 7

TABLE OF AUTHORITIES
(continued)

Page(s)

Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 435 (2015) 14

World Health Org., Clinical Practice Handbook for Safe Abortion (2014), http://apps.who.int/iris/bitstream/10665/97415/1/9789241548717_eng.pdf 7

Laurie Schwab Zabin et al., *When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy*, 21 Fam. Planning Persp. 248 (1989)..... 33

Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 Obstetrics & Gynecology 258 (2015)..... 9

RULES

Rule 37.6..... 1

REGULATIONS

38 Tex. Reg. 6546 (Sept. 27, 2013) 13

INTEREST OF AMICI CURIAE[1]

Amici curiae are social science researchers who have collectively spent decades conducting and publishing research about the safety and incidence of abortion in the United States. In particular, their research focuses on what effect state regulations have on the health of women seeking legal abortions.

In *Gonzales v. Carhart*, this Court identified a lack of data measuring the impact of abortion on women's mental health and wellbeing.[2] In the years since that decision, researchers from across the country have rigorously examined the impact of abortion on women—conducting epidemiological studies of abortion complications, health services research on women's experiences seeking care, and economic research on fertility and family planning. Amici include dozens of individual researchers working in this field, as well as the Guttmacher Institute, a private, non-profit research and policy organization that conducts research on access to abortion and evaluates state laws and policies on abortion.

Amici are therefore well suited to assess the effects of Texas House Bill 2 on women's health. Amici have an interest in ensuring that analyses of laws purporting to improve women's health are grounded in robust scientific research. Methodologically sound

---

[1] Pursuant to Rule 37.6, amici state that no counsel for any party has authored this brief in whole or in part, and no person other than amici or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

[2] *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).

research should include appropriate comparison groups, rely on prospective data, have longitudinal design, clearly distinguish correlation and causation, and rely on representative samples of the population. As amici's thorough research has shown, abortion is already very safe, and laws that create barriers to abortion services harm, rather than improve, women's health.

A full list of amici is attached as an appendix to this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

Texas House Bill 2 ("HB2")[3] imposes a variety of new requirements on abortion providers in Texas. As relevant here, HB2 requires that (i) abortion providers hold admitting privileges at a hospital within thirty miles of where the abortion is performed (the "admitting privileges requirement"), and (ii) licensed abortion facilities meet standards equivalent to ambulatory surgical centers (the "ASC requirement").[4]

The stated purpose of these restrictions is to improve the quality of care and ensure women's health and safety.[5] But as scientific studies demonstrate,

---

[3] 83rd Leg., 2nd Spec. Sess. (Tex. 2013) (codified at Tex. Health & Safety Code Ann. §§ 171.0031, 171.041 to .048, 171.061 to .064, 245.010 to .011).

[4] Tex. Health & Safety Code Ann. §§ 171.0031(a)(1)(A), 245.010(a).

[5] *Whole Woman's Health v. Cole*, 790 F.3d 563, 576 (5th Cir.) [hereinafter *Whole Woman's Health II*], *modified*, 790 F.3d 598 (5th Cir.), *and cert. granted*, 136 S. Ct. 499 (2015).

these requirements have no health or safety benefits. Abortion is *already* one of the safest medical procedures performed in the United States—complications arise from abortions less frequently than from many other common outpatient procedures not subject to similar legal restrictions. And HB2's provisions do not make abortion any safer: prevailing medical practice makes plain that there is no health or safety benefit to the ASC requirement, and Texas law already requires abortion providers to have detailed plans for the provision of emergency services in the unlikely event of a complication.

In recent years, state legislatures have passed a broad array of new abortion regulations in the same vein as HB2: between 2011 and 2015, states enacted 288 new abortion restrictions, and nearly 400 new restrictions were introduced in 2015 alone.[6] But HB2's ASC and admitting privileges provisions are unique in the breadth of their impact on abortion access. In a state that is home to 5.4 million reproductive-age women, the number of abortion clinics has already decreased by almost half, down from more than forty prior to HB2's enactment.[7] If the Fifth Circuit's decision is affirmed, the number of clinics will drop to ten or fewer.[8] For hundreds of thousands of Texas women, HB2 will put the nearest abortion clinic effectively out of reach. For others,

---

[6] *Trends in the States, 2015*, Guttmacher Inst., http://www.guttmacher.org/statecenter/updates/2015/statetrends42015.html (last visited Jan. 2, 2016).

[7] J.A. 228, 1429.

[8] *Id.* at 1434.

widespread clinic closures will result in longer wait times and significantly increased travel distances, leading not only to additional expense but also to delay in accessing care.

The rigorous scientific research set forth below demonstrates that delayed or denied access to abortion has significant negative consequences for women's health. These two provisions of HB2 will make it more difficult for women to obtain care during the earliest stages of pregnancy, when abortion is safest. As a result, many women may undergo second-trimester abortions or attempt to self-induce, both of which pose greater risks to health and safety. In addition to the direct medical risks, social science research demonstrates that restricting access to abortion can have negative mental, emotional, and socioeconomic consequences for women.

Available scientific studies show, in other words, that the effect of the admitting privileges and ASC requirements on women's health and safety will be precisely the opposite of what HB2's proponents assert. In this politically charged area, it is particularly important that assertions about health and safety are evaluated using reliable scientific evidence. Since the 1970s, research has consistently shown that abortion is a safe and common medical procedure. And the available epidemiological evidence demonstrates that HB2's provisions not only fail to improve health and safety, but also actively harm women.

ARGUMENT

I. TEXAS CLAIMS THAT HB2 PROTECTS WOMEN'S HEALTH, BUT ABORTION IS ALREADY VERY SAFE, AND HB2 DOES NOT MAKE IT SAFER.

The two provisions of HB2 at issue in this case—the ASC requirement and the admitting privileges requirement—are extreme examples of a broader pattern of regulations that reduce abortion access (collectively, "targeted regulation of abortion providers" or "TRAP laws"). Like other TRAP laws, these provisions of HB2 are premised on the assertion that they promote the health and safety of women seeking abortion care.[9] Such claims, however, have no scientific support. In reality, abortion is a very safe medical procedure, and the ASC and admitting privileges provisions do nothing to improve patient health or safety.

A. Abortion Is a Safe, Common Medical Procedure.

Abortion is already a very safe, common medical procedure. An estimated three in ten women will have an abortion before the age of 45.[10] Though the number of abortions performed annually in the

---

[9] *See Whole Woman's Health II*, 790 F.3d at 576 (noting that the Texas Legislature's stated purposes in enacting HB2 were to "raise the standard and quality of care" and to "protect the health and welfare" of women seeking abortions).

[10] Rachel K. Jones & Megan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 Obstetrics & Gynecology 1358, 1365 (2011).

United States is declining, more than one million abortions were performed in 2011, the most recent year for which comprehensive data are available.[11] Prior to the adoption of HB2, around 70,000 abortions were performed annually in Texas.[12] Abortion patients include women of every race, religion, and socioeconomic group.[13]

---

[11] Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 Persp. on Sexual & Reprod. Health 3, 5 (2014). The number of abortions declined steadily from 1991 to 2005 (from 26.3 to 19.4 per 1000 reproductive-age women), remained roughly steady until 2008, and then declined between 2008 and 2011 (to 16.9 per 1000 women). *Id.* at 6. This decline is likely due to a number of factors, including decreased access to abortion providers, increased stigmatization of abortion, increased social acceptance of carrying unintended pregnancies to term, and increased access to more effective forms of birth control. *Id.* at 12; *see also* Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008*, 104 Am. J. Pub. Health S43, S47 (Supp. 1, 2014). Limited 2012 data from the CDC suggest the decline is continuing. *See* Karen Pazol et al., *Morbidity & Mortality Weekly Report: Abortion Surveillance — United States, 2012*, Ctrs. for Disease Control & Prevention (Nov. 27, 2015), http://www.cdc.gov/mmwr/pdf/ss/ss6410.pdf.

[12] *See* Jones & Jerman, *supra* note 11, at 7 (estimating 73,200 abortions were performed in Texas in 2011).

[13] *See* Rachel K. Jones et al., *Characteristics of U.S. Abortion Patients, 2008*, Guttmacher Inst. 12–14 (May 2010), https://www.guttmacher.org/pubs/US-Abortion-Patients.pdf (discussing demographic trends among abortion patients).

Nationally, the vast majority of abortions—89%—are performed in the first trimester of pregnancy.[14] A growing percentage of abortions (about one-third of all early abortions) are performed using medication,[15] a procedure that requires no equipment or special facilities. Most medication-abortion patients, after consulting with a licensed provider and taking the initial medication in the clinic, take the second medication at home.[16] Aspiration abortion—the most common method of first-trimester abortion—is typically performed without general anesthesia and takes only a few minutes to complete.[17] In the United States, the vast majority of abortions are performed in offices or clinics; only about 4% are performed in hospitals.[18]

---

[14] *Fact Sheet: Induced Abortion in the United States*, Guttmacher Inst. (July 2014), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

[15] Jones & Jerman, *supra* note 11, at 11.

[16] *See What is Medical Abortion?*, Nat'l Abortion Fed'n (Sept. 2008), http://5aa1b2xfmfh2e2mk03kk8rsx.wpengine.netdna-cdn.com/wp-content/uploads/medical_abortion.pdf.

[17] Lisa M. Keder, *Best Practices in Surgical Abortion*, 189 Am. J. Obstetrics & Gynecology 418, 419 (2003); Katharine O'Connell et al., *First-Trimester Surgical Abortion Practices: A Survey of National Abortion Federation Members*, 79 Contraception 385, 389 (2009); *see also* World Health Org., Clinical Practice Handbook for Safe Abortion 26 (2014), http://apps.who.int/iris/bitstream/10665/97415/1/9789241548717_eng.pdf.

[18] Jones & Jerman, *supra* note 11, at 4.

Complication rates from abortion are very low—between 1% and 4% for first-trimester abortions.[19] Most abortion complications are minor, including easily treatable infections and medication abortions that later require aspiration.[20] Major complications are extremely rare, occurring at a rate of approximately 0.23%[21] to 0.40%[22] across gestational ages.

The risk of death from an abortion, moreover, is extraordinarily low: in the four years leading up to

---

[19] *See, e.g.*, Ian M. Bennett, *Early Abortion in Family Medicine: Clinical Outcomes*, 7 Annals Family Med. 527, 531 (2009) (finding that less than 4% of first-trimester medication and aspiration abortions had any related complications); Alisa B. Goldberg et al., *Manual Versus Electric Vacuum Aspiration for Early First-Trimester Abortion: A Controlled Study of Complication Rates*, 103 Obstetrics & Gynecology 101, 105 (2004) (finding a 2.1 to 2.5% complication rate for aspiration abortions); Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 457 (2013) (finding 1.3% of aspiration abortions resulted in a complication).

[20] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 182 (2015).

[21] *Id.* at 181 (defining "major complications" as requiring hospitalization, surgery, or a blood transfusion).

[22] James W. Buehler et al., *The Risk of Serious Complications from Induced Abortions: Do Personal Characteristics Make a Difference?*, 153 Am. J. Obstetrics & Gynecology 14, 16 (1985) (defining "serious complications" as prolonged high fever, blood transfusions, surgery, or death).

the passage of HB2, no women in Texas died from an abortion.[23] Nationally, fewer than one in 100,000 abortion patients die from an abortion-related complication.[24] That means a person is fourteen times more likely to be struck by lightning than a woman is to die from having an abortion.[25]

B. Strict Regulations Like HB2 Do Not Apply to Many Outpatient Procedures that Are Riskier than Abortion.

Despite Texas's argument that HB2's requirements will improve women's health and safety, the state does not require other outpatient procedures—even those that are more technically complex or that have a greater risk of complications than abortion—

---

[23] Tex. Dep't of State Health Servs., *Vital Statistics Annual Reports*, http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm (last updated Oct. 15, 2015).

[24] The mortality rate for abortion is approximately 0.0007%. Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 Obstetrics & Gynecology 258, 261 (2015); *see also* Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion—Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 732 (2004) (estimating a rate of 0.0007% for 1988–1997); Pazol et al., *supra* note 11, at 11 (estimating a rate of 0.0007% for 2008–2011); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012) (estimating a rate of 0.0006% for 1998–2005).

[25] *See How Dangerous is Lightning?*, Nat'l Weather Service, http://www.lightningsafety.noaa.gov/odds.shtml (last visited Dec. 30, 2015) (stating that the chance of being struck by lightning in one's lifetime is approximately one in 12,000, or 0.008%).

to be performed in an ASC or by a physician with admitting privileges. This uneven approach undermines Texas's assertion that HB2's provisions are intended to improve patient health.

Abortion is safer than many other common outpatient procedures. For example:

- The overall complication rate for abortion is much lower than for tonsillectomy, which is around 9%.[26]
- The risk of a major complication from an abortion is about the same as, or slightly less than, a colonoscopy.[27]
- The mortality rate for abortion is roughly the same as in-office dental surgery.[28]

---

[26] Jose Granell et al., *Safety of Outpatient Tonsillectomy in Children: A Review of 6 Years in a Tertiary Hospital Experience*, 131 Otolaryngology—Head & Neck Surgery 383, 386 (2004).

[27] The major complication rate for colonoscopy is approximately 0.24% to 0.28%, compared to 0.23% for abortion. *See* Georgina Castro et al., *Outpatient Colonoscopy Complications in the CDC's Colorectal Cancer Screening Demonstration Program*, 119 Cancer (Supp. S15) 2849, 2851 (2013); *Complications of Colonoscopy*, 74 Am. Soc'y of Gastrointestinal Endoscopy 745, 745 (2011) (finding 0.28% of colonoscopies resulted in a "serious adverse event").

[28] *See, e.g.*, Edward M. D'Eramo et al., *Anesthesia Morbidity and Mortality Experience Among Massachusetts Oral and Maxillofacial Surgeons*, 66 J. Oral & Maxillofacial Surgery 2421, 2421–22 (2008) (reviewing literature finding mortality rates between 0.001% and 0.003%).

Yet Texas law does not require any of these procedures to be performed in an ambulatory surgical center, nor does it require physicians to hold admitting privileges at local hospitals before performing them.[29] And similar non-invasive obstetric and gynecologic surgical procedures, like hysteroscopy and endometrial biopsy, are commonly performed in offices.[30]

The available evidence demonstrates that abortions are safe. Certainly, abortions are safer than many other less-regulated procedures. Singling out abortion for additional regulation despite its demonstrated safety does not improve women's health.

C. Research Demonstrates that These Two Provisions of HB2 Will Not Raise the Quality of Care or Promote Women's Health.

Setting aside the fact that abortion is already very safe, there is no evidence to suggest that HB2's ASC and admitting privileges requirements will make abortion any safer. Texas argues that the admitting privileges requirement will protect patients from unqualified providers and lead to greater conti-

---

[29] *See* Tex. Health & Safety Code Ann. § 243.004(1) (exempting offices or clinics of licensed physicians, dentists, or podiatrists from ASC requirement).

[30] *See* Richard D. Urman et al., *Safety Considerations for Office-Based Obstetric and Gynecologic Procedures*, 6 Revs. Obstetrics & Gynecology e8, e9–e10 (2013); *see also* Lisa M. Peacock et al., *Transition to Office-based Obstetric and Gynecologic Procedures: Safety, Technical, and Financial Considerations*, 58 Clinical Obstetrics & Gynecology 418, 431 (2015).

nuity of care.[31] It also asserts that the ASC requirement will ensure patients are not relegated to substandard clinics, and that performing abortions in a sterile operating environment will improve patient health.[32] But the available evidence simply does not support the position that these restrictions will make abortion any safer than it already is.

A licensed doctor's ability to obtain admitting privileges is not a reliable indication of his or her competence. Among other conditions, many hospitals require physicians to admit a certain number of patients annually to maintain their privileges.[33] This requirement is especially difficult for abortion providers because so few abortions require a hospital admission due to a complication.[34] Perversely, there-

---

[31] *Whole Woman's Health II*, 790 F.3d at 579.

[32] *Id.*

[33] *See, e.g., Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 792 (7th Cir. 2013) (noting that admitting privileges criteria include "how frequently the physician uses the hospital (that is, the number of patient admissions), the quantity of services provided to the patient at the hospital, the revenue generated by the physician's patient admissions, and the physician's membership in a particular practice group or academic faculty "); Sandhya Somashekhar, *Admitting-Privileges Laws Have Created High Hurdle for Abortion Providers to Clear*, Wash. Post (Aug. 10, 2014), https://www.washingtonpost.com/national/2014/08/10/62554324-1d88-11e4-82f9-2cd6fa8da5c4_story.html ("[M]any clinics have found getting these privileges very difficult. Their doctors often live too far away from the hospitals or cannot commit to admitting the minimum number of patients required for such a relationship.").

[34] Only approximately 0.03% of abortions require a same-day ambulance transfer to an emergency room. *See* Upadhyay

fore, one of the reasons compliance with the admitting privileges requirement is so difficult is that abortion is so safe.

Nor does the admitting privileges requirement improve continuity of care. Existing Texas law and prevailing medical practice already require that providers have an established plan for the provision of emergency services.[35] Texas law also already requires abortion providers to either have admitting privileges or "have a working arrangement" with a physician with privileges "in order to ensure the necessary back up for medical complications."[36] Moreover, the admitting privileges requirement is irrelevant for women who experience complications from abortion after returning home, since they would likely travel to whichever hospital is closest to them. Because reports estimate that, if the Fifth Circuit's decision is upheld, approximately one million Texas

---

et al., *supra* note 20, at 180. And only 6.4% of women receiving an abortion seek treatment in an emergency department within six weeks of the abortion. *Id.* Of those, the majority (59.2%) seek emergency care for reasons unrelated to the abortion. *Id.* at 180–81.

[35] *See* 25 Tex. Admin. Code § 139.56(a) ("A licensed abortion facility shall have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital."); Nat'l Abortion Fed'n, 2015 Clinical Policy Guidelines 42 (2015) ("Protocols for the management of medical emergencies must be in place. These protocols must include indications for emergency transport and written, readily available directions for contacting external emergency assistance (e.g., an ambulance).").

[36] 38 Tex. Reg. 6546 (Sept. 27, 2013).

women will be more than 150 miles from their closest abortion provider, it is unlikely the nearest hospital will be the one where their abortion provider holds privileges.[37]

The ASC requirement is similarly unnecessary. ASCs are designed to permit invasive outpatient surgical procedures to be performed outside of hospitals, which is why, among other requirements, ASCs must have an operating room.[38] But abortions do not require the use of an operating room. Indeed, 96% of abortions in the United States are performed in non-hospital settings.[39] Requiring clinics to build and maintain unnecessary facilities does nothing to improve patient safety: a recent comprehensive review of medical literature found no difference in the major complication rate among procedures performed in offices, ASCs, or hospitals.[40]

---

[37] Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496, 498 (2014); Jennifer Ludden, *Court Decision On Texas Abortion Law Could Hasten Clinic Closures*, Nat'l Public Radio (June 10, 2015), http://www.npr.org/sections/health-shots/2015/06/10/413318079/in-texas-federal-court-backs-abortion-restriction-law.

[38] *See* Tex. Health & Safety Code Ann. § 243.002(1) (defining "ambulatory surgical center" as "a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care").

[39] Jones & Jerman, *supra* note 11, at 4.

[40] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 435 (2015).

In short, neither of the HB2 requirements at issue in this case will improve the health or safety of women seeking abortions. Only licensed clinicians may perform abortions in Texas, and, in the rare case of a complication, patients can already receive care in the closest emergency room. Nor is there any medical reason to require abortion clinics to meet the physical standards of ASCs, making these two provisions completely unnecessary. Available evidence simply does not support Texas's claim that HB2 will improve women's health.

II. HB2 AND OTHER TRAP LAWS RESTRICT ACCESS TO ABORTION BY REDUCING THE NUMBER OF AVAILABLE PROVIDERS.

Although Texas asserts that HB2 was designed to improve patient health and safety, the law has, and will continue to, reduce the number of providers in the state, effectively making abortion inaccessible for thousands of women. TRAP laws enacted in other states have imposed similar barriers, dramatically reducing women's access to safe and legal abortion.

A. HB2's Primary Effect Will Be to Reduce the Number of Abortion Providers.

As explained, HB2's ASC and admitting privileges requirements do not make abortion safer, but they certainly make abortions more difficult to obtain. Access to safe and legal abortion in Texas has already been significantly reduced since portions of HB2 went into effect. In May 2013, prior to the implementation of HB2, there were more than forty fa-

cilities providing abortions in Texas.[41] Leading up to and immediately following implementation of portions of HB2—including the admitting-privileges requirement—in October 2013, the number of providers dropped by more than half.[42] Clinics outside of Texas's four major metropolitan areas were the most heavily affected: eleven out of these thirteen clinics closed.[43] If the Fifth Circuit's opinion stands, the number of providers will be further reduced to ten or fewer, less than a quarter of the number that existed before the passage of HB2.[44]

The dramatic reduction in the number of clinics providing abortion services has already made it much more difficult for women to obtain an abortion in Texas. Prior to the enactment of HB2, only about 10,000 reproductive-aged women lived more than 200 miles from the nearest Texas abortion provider.[45] By November 2013, after portions of the law were implemented, that number increased to 290,000, and if the remaining provisions of HB2 are implemented, it will spike to nearly 800,000.[46] In other words, if the Fifth Circuit is affirmed, it would increase by eighty times the number of women who are more than 200 miles from their nearest abortion provider.

---

[41] Grossman et al., *supra* note 37, at 498.

[42] *Id.*

[43] *Id.*

[44] J.A. 1434.

[45] Grossman et al., *supra* note 37, at 498.

[46] *Id.* at 499.

These obstacles may have already prevented women from accessing abortion care. In the six-month period after portions of HB2 took effect, the total number of abortions in Texas decreased by 13%, and the number of medication abortions dropped by 70%, compared to the same period a year earlier.[47] The decline in abortion was steeper for first-trimester procedures, and there was a small but significant increase in the proportion of abortions performed in the second trimester.[48] If the remaining provisions of HB2 are allowed to go into effect, it will create additional obstacles and delays for women, resulting in more second-trimester abortions and less access to abortion care in general.[49] Indeed, research suggests that the ASC requirement alone may double the number of second-trimester abortions in Texas due to increased wait times.[50] Because vulnerable populations are already more likely to have second-trimester procedures,[51] they may be disproportionately affected by these additional obstacles.

---

[47] *Id.*

[48] *Id.*

[49] *See Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*, Tex. Pol'y Evaluation Project Res. Brief 6 (Oct. 5, 2015), https://utexas.app.box.com/AbortionWaitTimeBrief.

[50] *Id.*

[51] *See* Rachel K. Jones & Lawrence B. Finer, *Who Has Second-Trimester Abortions in the United States?*, 85 Contraception 544, 546–47, 549 (2012) (finding that adolescents, Black women, women with less education, and low-income women are more likely to have second-trimester procedures).

Texas has acknowledged that the real-world context in which women make decisions must factor into the undue burden analysis.[52] Justices of this Court have recognized the same.[53] The available evidence makes clear that the real-world effect of these two provisions of HB2 will not be to improve women's health or safety. Instead, they will only create more obstacles for women seeking to exercise their right to an abortion.

B. Research Shows that TRAP Laws Close Abortion Facilities and Do Not Protect Women's Health.

Texas is not the only state to enact restrictions that limit women's access to abortion, but these two provisions of HB2 are uniquely extreme in their impact. Twenty-four states have passed some form of TRAP law, often relying on similar unfounded claims

---

[52] *Whole Woman's Health v. Lakey*, 769 F.3d 285, 308 n.3 (5th Cir.) (J. Higginson, concurring in part and dissenting in part), *vacated in part*, 135 S. Ct. 399 (2014).

[53] *See, e.g.*, *Fargo Women's Health Org. v. Schafer*, 507 U.S. 1013, 1014 (1993) (mem.) (O'Connor, J., joined by Souter, J., concurring) (noting that the joint opinion in *Casey* "specifically examined the record developed in the district court" to determine whether the statute operated as a substantial obstacle to a large fraction of the women actually affected by it); *Planned Parenthood of Se. Pa. v. Casey*, 947 F.2d 682, 711 (3d Cir. 1991) (opinion joined by then-Judge Alito noting that "[t]he Supreme Court has thus been attuned to the real-world consequences" of abortion restrictions in determining whether an undue burden exists), *aff'd in part, rev'd in part*, 505 U.S. 833 (1992).

about improving patient health and safety.[54] Though HB2 stands alone in the breadth of its impact on access to abortion, TRAP laws generally work to establish an obstacle course for women seeking access to safe and legal abortion, especially when enacted in combination with other abortion restrictions.[55] For example, in addition to the two HB2 provisions at issue here, Texas has enacted laws that impose a mandatory waiting period and sonogram,[56] restrict the availability of medication abortion,[57] re-

---

[54] *State Policies in Brief: Targeted Regulation of Abortion Providers*, Guttmacher Inst. (Dec. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.

[55] *See Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 686 (W.D. Tex. 2014) [hereinafter *Whole Woman's Health I*] (noting that the ASC requirement, particularly when combined with other barriers, like Texas's mandatory sonogram requirement and waiting period, imposes an undue burden), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir.), *modified*, 790 F.3d 598 (5th Cir.), *and cert. granted*, 136 S. Ct. 499 (2015).

[56] Tex. Health & Safety Code Ann. §§ 171.011 to 171.018. Texas's law requires an additional in-person visit and sonogram before the procedure, increasing the personal and financial costs of obtaining an abortion and thereby preventing some women from obtaining abortion services. Theodore J. Joyce et al., *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review*, Guttmacher Inst. 15 (Apr. 2009), https://www.guttmacher.org/pubs/MandatoryCounseling.pdf.

[57] Tex. Health & Safety Code Ann. §§ 171.061 to 171.064. Four states (including Texas) require medication abortions be performed according to outdated FDA or ACOG protocols, in addition to other restrictions. *State Policies in Brief: Medication Abortion*, Guttmacher Inst. (Jan. 1, 2016), http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf. Requiring clini-

quire abortions after sixteen weeks gestation to be performed in an ASC or hospital,[58] and ban all abortions after twenty weeks gestation.[59] In 2004, after Texas mandated that all abortions after sixteen weeks gestation be performed in a hospital or an ASC, the number of women who travelled out of state for a post-sixteen-week abortion almost quadrupled.[60] One of the reasons HB2's effects are so extreme is this existing backdrop of restrictions on ac-

---

cians to adhere to the outdated FDA protocol means that women are subject to a higher dose of medication than current standards recommend—600 mg of mifepristone instead of 200mg—and that the second dose of medication (misoprostol) must be taken in the presence of a doctor. Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion*, 16 Guttmacher Pol'y Rev. 18, 19 (2013). When HB2's medication-abortion requirement was implemented, seven facilities stopped providing the service, resulting in a 70% decrease in medication abortions. Grossman et al., *supra* note 37, at 499.

[58] Tex. Health & Safety Code Ann. § 171.004.

[59] Tex. Health & Safety Code Ann. §§ 171.041 to 171.048. Forty-three states prohibit abortions after a certain point in pregnancy: twenty-one states do so at the point of viability; three states do so at the start of the third trimester; and nineteen states do so at a certain number of weeks, most commonly at twenty weeks post-fertilization or twenty-two weeks after the last menstrual period. *State Policies in Brief: State Policies on Later Abortions*, Guttmacher Inst. (Dec. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_PLTA.pdf.

[60] *See* Theodore Joyce, *The Supply-Side Economics of Abortion*, 365 N. Eng. J. Med. 1466, 1467 (2011). A year after the law took effect, there was a 68% decline in abortions at sixteen weeks or later for Texas residents. *Id.*

cess to abortion, which other states are beginning to emulate.

Sixteen states have passed laws similar to HB2's admitting privileges requirement.[61] Louisiana's admitting privileges requirement (which is virtually identical to HB2's)[62] could result in the closure of at least three of the state's five remaining abortion facilities.[63] As a consequence, the mean distance Louisiana women would need to travel to obtain an abortion could triple, from 58 miles to 208 miles each way.[64] In Wisconsin, had the state's admitting privileges statute not been enjoined, it would have immediately closed two of the state's four abortion clinics and reduced capacity at a third clinic.[65] Mississippi's

---

[61] *See* Guttmacher Inst., *supra* note 54.

[62] La. Stat. Ann. § 40:1061.10(A)(2)(a).

[63] S.C.M. Roberts et al., *Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges*, 91 Contraception 368, 368 (2015).

[64] *Id.* at 371. Louisiana residents who must travel out of state for abortion care because of clinic closures may also be affected by TRAP laws in neighboring states, such as Mississippi, Texas, and Alabama. *Id.* at 369. Of course, the reverse is also true, with women who would otherwise travel to Louisiana from neighboring states, such as Texas, facing reduced access even across state lines. *See id.* at 370 (noting that, in one study, 15% of women seeking care at a Louisiana facility were Texas residents).

[65] *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 912 (7th Cir. 2015).

statute, had it not been enjoined, would have closed the only abortion clinic remaining in the state.[66]

Some states have also enacted regulations, like HB2's ASC provision, requiring abortion providers to meet certain structural standards beyond those generally required for doctors' offices.[67] Compliance with these regulations can be extremely costly. Regulations that went into effect in 2012 in Pennsylvania required clinics to spend hundreds of thousands of dollars on renovations to replace flooring and HVAC systems.[68] Virginia recently enacted requirements similar to HB2's ASC provision that would have required clinics to spend, on average, between $700,000 and $969,000 per site to comply.[69] In response to these laws, clinics must either close, charge more for their services, or find other ways to remain in operation.

Studies confirm that, as a result of these restrictions, access to abortion becomes more difficult and expensive. The average out-of-pocket cost for an abortion is approximately $474.[70] The median price

---

[66] *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 452 (5th Cir. 2014).

[67] *E.g.*, Mich. Comp. Laws § 333.20115(2); Mo. Rev. Stat. § 197.200(1); Va. Code Ann. § 32.1-127(B)(1).

[68] Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, 16 Guttmacher Pol'y Rev. 7, 11 (2013).

[69] *Id.*

[70] Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues e211, e214 (2014) (noting that out-of-pocket costs

of an abortion in the first trimester is $490, and the median price between fourteen and twenty weeks is $750, meaning a delay into the second trimester costs, on average, $260.[71] After twenty weeks, the median price increases to $1,750.[72] Between 18% and 37% of women who would otherwise seek a Medicaid-funded abortion cannot access abortion services when this funding is unavailable.[73] These figures do not even account for other costs women must incur to obtain an abortion, including traveling (potentially hundreds of miles) to their nearest provider, taking time off work, and obtaining childcare. Because of Texas's existing waiting period and sonogram requirements, women may need to incur all of these costs twice for a single procedure.[74]

Cost—both for travel and for the procedure—is one of the primary causes for delay in obtaining an

---

can be as high as $3,700); *see also* Jenna Jerman & Rachel K. Jones, *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, 24 Women's Health Issues e419, e421 tbl.1 (2014) (reporting that the mean amount paid for surgical abortion at 10 weeks is $480, and the mean for medication abortions prior to 10 weeks is $504).

[71] Prices between fourteen and twenty weeks can range as high as $1,500, meaning that delay may cost significantly more. Roberts, *supra* note 70, at e214.

[72] *Id.*

[73] Stanley K. Henshaw et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, Guttmacher Inst. 27 (June 2009), https://www.guttmacher.org/pubs/MedicaidLitReview.pdf.

[74] *See* discussion *supra* note 56.

abortion.[75] Women report having to delay or not pay bills for rent, food, utilities, and other essentials in order to pay for an abortion.[76] More than half of women report that raising money for the abortion delayed their procedure.[77] Some women delayed for financial reasons postpone their abortion as long as two to three weeks, and in some cases into the second trimester, which only increases costs.[78] Other major reasons for delay are not knowing where to find abortion care and not having means to travel to an abortion provider.[79] All of these causes for delay are exacerbated when clinics become more scarce.

HB2 is, in short, a particularly dramatic example in a long line of regulations operating to impede women's access to abortion by reducing the number of available clinics and raising costs. If the Fifth Circuit's decision is upheld, states opposed to abortion will continue to restrict access through increasingly burdensome regulations. As a result, for many women, the right to access abortion services will effectively evaporate.

---

[75] Diana Greene Foster & Katrina Kimport, *Who Seeks Abortions at or After 20 Weeks?*, 45 Persp. on Sexual & Reprod. Health 210, 212–15 (2013); Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. of Pub. Health 1687, 1692 (2014).

[76] Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173, e176 (2013).

[77] Roberts, *supra* note 70, at e215.

[78] Henshaw et al., *supra* note 73, at 28.

[79] Upadhyay, *supra* note 75, at 1687.

III. RESTRICTING ACCESS TO ABORTION ACTIVELY HARMS WOMEN'S HEALTH AND WELLBEING.

HB2's provisions not only fail to improve women's health, they actively cause women harm. If HB2 is fully implemented, it will dramatically reduce the number of abortion providers in Texas, increase wait times and the average distance women must travel to obtain an abortion, force many women to seek care in other states,[80] and raise the costs of the procedure. The available evidence shows that these delays and increased costs hurt women—physically, psychologically, and economically.

A. Delaying or Effectively Denying Access to Abortion Negatively Affects Women's Physical Health.

As explained, reducing access to abortion increases the likelihood that the procedure will be delayed until a later gestational period.[81] Since portions of HB2 were implemented, the percentage of abortions performed in the second trimester has increased, even though the overall number of abortions has decreased.[82] If the Fifth Circuit's opinion is affirmed, the percentage of abortions performed in the second trimester will likely rise further.

---

[80] *See* Joyce, *supra* note 60, at 1467.

[81] *See supra* notes 75–79 and accompanying text. *See also* Marianne Bitler & Madeline Zavodny, *The Effect of Abortion Restrictions on the Timing of Abortions*, 20 J. Health Econ. 1011, 1021–27 (2001).

[82] Grossman et al., *supra* note 37, at 499.

Even though abortion is very safe, delaying the procedure increases the medical risks to the patient because the chance of a major complication is higher in the second trimester than in the first.[83] Delay also makes it more likely that a woman will be unable to obtain an abortion before Texas's twenty-week gestational limit.[84] Even before Texas's and other states' gestational limits were implemented, social scientists estimated that approximately four thousand women in the United States were denied abortions each year because of gestational limits.[85] If HB2 goes into full effect, hundreds of thousands of women will face reduced access to abortion care, and the number of women unable to obtain an abortion before Texas's gestational limit will likely rise.

Denying a woman a wanted abortion—and thus forcing her to carry the pregnancy to term—increases the risk of injury and death. Approximately 28.6% of hospital deliveries involve at least one obstetric complication,[86] compared to the 1% to 4% for first-trimester abortion. A hospital delivery is also more than three times as likely as a second-

---

[83] Upadhyay et al., *supra* note 20, at 181; *see also* Willard Cates, Jr. et al., *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Planning Persp. 266, 268 (1977) ("Our findings clearly demonstrate that *any* delay increases the risk of complications to a pregnant woman who wishes an abortion.").

[84] Tex. Health & Safety Code Ann. § 171.044.

[85] Upadhyay et al., *supra* note 75, at 1692.

[86] Cynthia J. Berg et al., *Overview of Maternal Morbidity During Hospitalization for Labor and Delivery in the United States*, 113 Obstetrics & Gynecology 1075, 1077 (2009).

trimester abortion to result in a major complication.[87] A woman is fourteen times more likely to die from giving birth than as a result of an abortion.[88]

The inability to access abortion care may also cause more Texas women to attempt self-induction.[89] A recent study estimates that at least 100,000 Texas women have, at some point in their lives, attempted to self-induce an abortion.[90] And research suggests that self-induced abortion is more common in Texas than in other parts of the country, possibly due to the state's proximity to Mexico, where misoprostol (a

---

[87] *See* William M. Callaghan et al., *Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States*, 120 Obstetrics & Gynecology 1029, 1034 (2012) (reporting that approximately 52,000 of the annual 4,000,000 births in the United States, or 1.3%, will experience severe maternal morbidity).

[88] *See* Raymond & Grimes, *supra* note 24, at 216.

[89] *See* Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 73 (2014) ("The confluence of extremely limited access to abortion in the context of poverty, access to misoprostol from Mexico, as well as familiarity with the practice of self-induction in Latin America, makes it particularly likely that self-induction will become more commonplace in Texas."); *Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options*, Tex. Pol'y Evaluation Project Res. Brief (Nov. 17, 2015), https://utexas.app.box.com/WExSelfInductionResearchBrief (finding that two primary reasons for attempting self-induction were lack of money to travel to or pay for the procedure and the closure of the local clinic).

[90] D. Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Tex. Pol'y Evaluation Project Res. Brief 2 (Nov. 17, 2015), https://utexas.app.box.com/KOESelfInductionResearchBrief.

drug that can cause an early abortion) is available without a prescription.[91] In addition to misoprostol, commonly reported methods of attempted self-induction are herbal or homeopathic remedies, getting hit or punched in the abdomen, using alcohol or illicit drugs, or taking hormonal pills.[92]

Though not all methods of self-induction are inherently unsafe, some certainly are, and in general self-induction carries greater risks than medically supervised abortion.[93] Moreover, the increase in attempted self-induction that will likely result from HB2's restrictions undermines one of the basic premises of Texas's argument for why the law is necessary in the first place. If, as Texas claims, abortion should be more heavily regulated and performed only in a sterile setting by a provider with admitting privileges, increasing the number of self-induced abortions—which, by definition, occur under conditions with fewer safety measures than clinics and medical offices—would squarely undermine that goal. HB2's burdensome regulation of abortion providers will thus result in a higher percentage of

---

[91] *Id.* at 1.

[92] *Id.* at 3.

[93] For example, use of misoprostol in the second trimester rather than the first trimester increases the risk of hemorrhage; if inappropriately high dosages are used there is a higher risk of uterine rupture, especially if the patient has a history of prior cesarean delivery. Grossman et al., *supra* note 89, at 74; *see also* Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18 Reprod. Health Matters 136, 143 (2010) (discussing medical and legal risks associated with self-induced abortion).

abortions being performed in an environment subject to no regulation at all.[94]

While reduced availability of abortion services harms women, increased availability is generally correlated with improvements in public health. States that provide public funds for abortions, for example, have lower racial disparities in congenital-anomaly-related infant deaths[95] and lower rates of postpartum depression.[96] Research has also found that women denied wanted abortions are more likely to experience continued intimate partner violence from the man involved in the pregnancy than women who are able to receive a wanted abortion.[97]

Reducing access to abortion thus does not improve health or safety. On the contrary, obstacles to access lead to delays, which increases the likelihood

---

[94] Grossman et al., *supra* note 90, at 4 ("Given that the populations we found to be most familiar with abortion self-induction are among those that have been most directly affected by the closure of abortion clinics in the state, we suspect that abortion self-induction will increase as clinic-based care becomes more difficult to access.").

[95] Jennifer A. Hutcheon et al., *Medicaid Pregnancy Termination Funding and Racial Disparities in Congenital Anomaly-Related Infant Deaths*, 125 Obstetrics & Gynecology 163, 168 (2015).

[96] Marshall H. Medoff, *The Relationship Between Restrictive State Abortion Laws and Postpartum Depression*, 29 Soc. Work Pub. Health 481, 487 (2014).

[97] Sarah CM Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC Med., Sept. 2014, at 1, 4.

that women will be subject to significantly greater medical risks.

B. Restricting Access to Abortion Does Not Improve Women's Mental and Emotional Health.

Reducing access to abortion also has no positive effect on women's mental and emotional health, and may in fact be detrimental. In *Gonzales v. Carhart*, this Court stated that, though "no reliable data [were available] to measure the phenomenon," presumably "some women come to regret their choice" to have an abortion and that "[s]evere depression and loss of esteem can follow."[98] While earlier literature on mental health and emotional responses to abortion suffered from methodological shortcomings,[99] more recent studies and systematic reviews of the literature—including a report by the American Psychological Association—have found that abortion does not have a negative impact on women's mental health.[100]

---

[98] *Gonzales*, 550 U.S. at 159.

[99] *See* Corinne H. Rocca et al., *Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States*, 45 Persp. on Sexual & Reprod. Health 122, 122 (2013) (discussing shortcomings of previous studies); Brenda Major et al., Report of the APA Task Force on Mental Health and Abortion, 2008, http://www.apa.org/pi/women/programs/abortion/mental-health.pdf (same).

[100] Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 439–448 (2008); Susan A. Cohen, *Still True: Abortion Does Not Increase Women's Risk of Mental Health Problems*, 16 Guttmacher Pol'y Rev. 13, 13–14 (2013);

Having an abortion is not correlated with an increased likelihood of symptoms of depression or anxiety compared to carrying an unwanted pregnancy to term.[101] Nor is it correlated with a higher rate of diagnosis of mental health disorders.[102] Over time, most women have more positive emotions about their abortion than negative ones,[103] with relief being the most common.[104] A recent longitudinal study found that the predicted probability of a woman reporting that abortion was the right decision for her was over 99% at each interview point over the three years following her abortion.[105] No evidence suggests that restricting access to abortion and causing

---

Julia R. Steinberg et al., *Abortion and Mental Health: Findings from the National Comorbidity Survey-Replication*, 123 Obstetrics & Gynecology 263, 265–69 (2014); Brenda Major et al., *Abortion and Mental Health: Evaluating the Evidence*, Am. Psychologist, Dec. 2009, at 863, 885–86; Major et al., *supra* note 99.

[101] D.G. Foster et al., *A Comparison of Depression and Anxiety Symptom Trajectories Between Women Who Had an Abortion and Women Denied One*, 45 Psychol. Med. 2073, 2080 (2015).

[102] M. Antonia Biggs et al., *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*, 105 Am. J. Pub. Health 2557, 2561 (2015).

[103] Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, PLOS ONE (July 8, 2015), http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0128832&representation=PDF.

[104] Rocca et al., *supra* note 99, at 128.

[105] Rocca et al., *supra* note 103.

delays does anything to improve mental health outcomes.[106]

There is, however, evidence that barriers to abortion access can have a negative impact on mental health. For example, approximately one week after seeking an abortion, women who are turned away because of gestational age limits are more likely to report symptoms of anxiety and lower self-esteem than women who receive an abortion.[107] There is thus no basis to conclude that abortion restrictions like those at issue in this case improve women's mental health.

C. Barriers to Abortion May Have Negative Socioeconomic Effects on Women and Children.

The most common reasons women seek to have an abortion are socioeconomic.[108] More than two-thirds of women obtaining abortions have family incomes less than 200% of the federal poverty line,[109] 85% are not married,[110] and 61% already have children.[111] Almost three quarters (73%) of abortion pa-

---

[106] *Id.* (finding no difference in emotional trajectories or decision regret between women having first-trimester versus later procedures).

[107] Biggs et al., *supra* note 102, at 2561.

[108] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, BMC Women's Health, July 2013, at 1, 5.

[109] Jones et al., *supra* note 13, at 6.

[110] *Id.* at 5.

[111] *Id.* at 8.

tients indicate they cannot afford to have a child now, including because they are unemployed, cannot afford childcare, cannot leave their job to take care of a child, or cannot afford the basic needs of life for themselves.[112]

Research confirms that women's concerns about their ability to provide for a child are often well founded. One recent study found women denied a wanted abortion were less financially secure than those who received an abortion.[113] One year after seeking an abortion, women who were denied an abortion were more likely than similarly situated women who obtained an abortion to be receiving public assistance (76% versus 44%), more likely to be living below the poverty level (67% versus 56%), and less likely to be employed full time (48% versus 58%).[114] Another study found that young women who chose to have an abortion were ultimately better off economically and educationally than their peers who carried to term.[115] Other studies have shown

---

[112] Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Persp. on Sexual & Reprod. Health 110, 112 (2005).

[113] Diana Greene Foster et al., Oral Presentation at the American Public Health Association 140th Annual Meeting: Socioeconomic Consequences of Abortion Compared to Unwanted Birth (Oct. 30, 2012), https://apha.confex.com/apha/140am/webprogram/Paper263858.html (presenting preliminary data pending completion of the five-year study).

[114] *Id.*

[115] Laurie Schwab Zabin et al., *When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy*, 21 Fam. Planning Persp. 248, 254 (1989).

that women who receive a wanted abortion are more likely to have vocational goals, have a positive outlook on their future, and achieve aspirational life plans within one year than women who are denied an abortion.[116]

Finally, because most women seeking an abortion already have children, restricted access to abortion may also have a negative impact on the health of their current and future children. Two nationwide studies of abortion patients have shown that, among patients with children, a commonly cited reason for choosing to have an abortion was the concern that having another child would compromise the care given to existing children.[117] Two thirds of the women who cited existing children as a reason for seeking an abortion were at or below the poverty line and received little assistance from their partners.[118] Restricted access to abortion has a disproportionate impact on these low-income women and their families.

In sum, recent social science and public health studies on the effects of abortion have thoroughly refuted claims that reducing access to abortion im-

---

[116] Ushma Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, BMC Women's Health, Nov. 2015, at 1, 6–9.

[117] Biggs et al., *supra* note 108, at 6; Finer et al., *supra* note 112, at 116–18.

[118] Rachel K. Jones et al., *"I Would Want to Give My Child, Like, Everything in the World": How Issues of Motherhood Influence Women Who Have Abortions*, 29 J. Fam. Issues 79, 88 (2008).

proves physical, mental, or economic wellbeing. HB2's ASC and admitting privileges requirements, in other words, are "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion."[119] Indeed, restrictions like those in HB2 have been shown to generally harm, rather than improve, the health of women, their children, and the general public.

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

ANTON METLITSKY
O'MELVENY & MYERS LLP
Times Square Tower
7 Times Square
New York, NY 10036
(212) 326-2000

WALTER DELLINGER
(*Counsel of Record*)
wdellinger@omm.com
DARCY M. MEALS
JEREMY R. GIRTON*
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

*Not yet admitted; supervised by principals of the firm.

Attorneys for Amici Curiae

January 4, 2016

---

[119] *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992).

APPENDIX

AMICI CURIAE[1]

Nancy Adler, PhD
University of California, San Francisco

Abigail R.A. Aiken, MD, MPH, PhD
Princeton University

Elizabeth Oltmans Ananat, PhD
Duke University

Jennifer S. Barber, PhD
University of Michigan

Sarah E. Baum, MPH
Ibis Reproductive Health

Danielle Bessett, PhD
University of Cincinnati

M. Antonia Biggs, PhD
University of California, San Francisco

Kelly Blanchard, MSc
Ibis Reproductive Health

Robert Wm. Blum MD, MPH, PhD
Johns Hopkins Bloomberg School of Public Health

Mara Buchbinder, PhD
University of North Carolina at Chapel Hill

Sarah K. Cowan, PhD
New York University

---

[1] Institutional affiliations provided for identification purposes only. The views expressed in this brief do not necessarily reflect the views of amici's affiliated institutions.

Amanda Dennis, DrPH, MBE
Colorado Health Foundation

Angel M. Foster, DPhil, MD, AM
University of Ottawa

Diana Greene Foster, PhD
University of California, San Francisco

Lori Freedman, PhD
University of California, San Francisco

Liza Fuentes, MPH
Ibis Reproductive Health
CUNY School of Public Health

Caitlin Gerdts, PhD, MHS
Ibis Reproductive Health

Melissa Gilliam, MD, MPH
The University of Chicago

Jessica D. Gipson, MPH, PhD
University of California, Los Angeles

Sofia Gruskin, JD, MIA
University of Southern California
Harvard T.H. Chan School of Public Health

Guttmacher Institute

Kelli Stidham Hall, PhD, MS
Emory University Rollins School of Public Health

Lisa H. Harris, MD, PhD
University of Michigan

Abigail Harrison, PhD
Brown University

S. Marie Harvey, DrPH, MPH
Oregon State University

Jenny A. Higgins, PhD, MPH
University of Wisconsin, Madison

Elizabeth Janiak, MA, MSc
Brigham and Women's Hospital
Harvard T.H. Chan School of Public Health

Sujatha Jesudason, PhD
CoreAlign

Carole Joffe, PhD
University of California, San Francisco

Rachel K. Jones, PhD
Guttmacher Institute

Theodore Joyce, PhD
Baruch College and Graduate Center, City University of New York

Katrina Kimport, PhD
University of California, San Francisco

Nancy Krieger, PhD
Harvard T.H. Chan School of Public Health

Kristin Luker, PhD
University of California, Berkeley

Brenda Major, PhD
University of California, Santa Barbara

Deborah R. McFarlane, DrPH, MPA
University of New Mexico

Joseph E. Potter, PhD
University of Texas at Austin

Lauren Ralph, PhD, MPH
University of California, San Francisco

Corinne H. Rocca, PhD, MPH
University of California, San Francisco

Marjorie Sable, DrPH, MSW
University of Missouri, Columbia

John Santelli, MD, MPH
Columbia University Mailman School of Public Health

Johanna Schoen, PhD
Rutgers University, New Brunswick

J. Joseph Speidel, MD, MPH
University of California, San Francisco

Julia R. Steinberg, PhD
University of Maryland, College Park

Amanda Jean Stevenson, MA
University of Texas at Austin

James Trussell, BPhil, PhD
Princeton University

Ushma D. Upadhyay, PhD, MPH
University of California, San Francisco

Kari White, PhD MPH
University of Alabama at Birmingham